STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: December 10, 11, 12, 13, 14, 17 18 & 19, 2012. Facility number: 000191 Provider number: 155294 AIM number: N/A Survey team: Marcy Smith RN TC Patti Allen BSW (December 10, 11, 12, 13, 17, 18 & 19, 2012) Dinah Jones RN (December 10, 11, 12, 13 & 14, 2012) Leia Alley RN (December 10, 11, 12, 13 & 14, 2012) Census bed type: SNF: 61 Residential: 23 Total: 84 Census payor type: Medicare: 32 Other: 52 Total: 84 These deficiencies also reflect State Findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed 12/21/12 Cathy Emswiller RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure hair covers were keeping hair from the residents' food, and temperatures were maintained for cold foods. This had the potential to affect 60 of 61 residents who ate meals prepared in the facility kitchen. Findings Include: During an observation of the facility kitchen on 12/10/12 at 11:30 a.m.,. food temperatures for cold foods about to be served by the kitchen were obtained. Two temperatures as followed were not maintained at 41 degrees F: (Fahrenheit) Chicken Salad 56 degrees F. Tuna Fish Salad 49 degrees F. During an interview at 11:35 a.m. on 12/10/12, with Chef #1, he indicated the chicken salad and tuna fish were not cold enough, and he would put the cold foods on ice to cool them	F0371	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law. In response to the cited Sanitary Conditions Code Violation (F371), the following changes are required: A.) With respect to these findings, no residents were adversely affected. B.) With respect to how the facility will identify residents with the potential for the identified concern and take corrective action: The Policy & Procedures for Hair Coverings and Cold Food Temperatures were immediately re-enforced. C.) With respect to what systemic measures have been put in place to address the stated concern: Staff was re-in-serviced for Policies of Dress code for wearing Hair Nets or Bouffant Caps and Safe Food Temperatures & Food Safety in Storage for Cold Food Temperatures (see attachments A, B, C,D) by 1/11/13. D.) With	01/12/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	down. During an observation at 12:15 p.m. on 12/10/12, Chef #1 had placed the containers of food on ice and the temperatures were as follows, Chicken Salad 39 degrees F. Tuna Salad 40 degrees F. During an observation of the kitchen on 12/10/12, at 11:30 a.m. the kitchen staff were observed to be wearing hair coverings, however were not wearing them properly. Chef #1 was observed to be wearing a "pony tail" style with a cap on and no hair net or bonnet. Cooks #1, #2 and Waitress #1 were observed to be wearing hair nets, however pieces of hair were hanging loosely around the face and under the hair net. The Food and Beverage Director was observed to have a hair net on, however it was placed on his head in such that the back lower half of his head and hair were hanging out of the hair net, uncovered. 3.1-21(i)(5)		respect to how the plan of corrective measures will be monitored: Beginning 1/12/13, the Director of Food & Beverage, Executive Chef, and Dietitian will be responsible for observing compliance with the policies. Observation will occur once each shift, daily for 2 weeks, then weekly for 90 days, then monthly there after. Staff found to be non-compliant will be counseled & disciplinary action taken up to and including termination. Findings will be reported to the Quality Assurance Committee. **E)** Date of compliance with proposed actions**: January 18, 2013**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review and interview, the facility failed to	F0441		01/18/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ensure a glucometer was cleaned according to facility policy, for 1 of 3 glucometer observations, having the potential to affect 2 residents receiving glucometer blood tests on the split unit. The facility also failed to ensure staff washed hands and wore gloves while administering medications to a resident in isolation on the back hall, for 1 of 2 residents observed while in isolation, having the potential to affect 22 residents receiving care on the 400 back unit. (Resident #169, #167 and #78) Findings include: 1. During an observation on 12/12/12 at 4:12 p.m., on the split unit, LPN #2 removed a glucometer (a device used to check blood sugars with a drop of blood from a fingerstick) from her medication cart drawer. At this time LPN #2 indicated the glucometer had already been cleaned. She checked the blood sugar of Resident #169. At 4:17 p.m. LPN #2 returned to her medication cart and cleaned the glucometer with an alcohol pad. She then indicated she needed to check the blood sugar of Resident #167. LPN #2 took the glucometer into Resident #167's room and prepared to do the blood sugar test. During an interview with LPN #2 at 4:25 p.m.		**Responses to the cited findings do not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.** In response to the cited findings R/T to **F441**, the following corrective actions will be taken: **A)** All residents residing in the facility who receive routine glucose monitoring via fingerstick have the potential to be affected by the alleged deficient practice of not cleaning glucometers with approved disinfectant solution (1:10 bleach) per policy and CDC guidelines for blood borne pathogens. All residents residing in the facility have the potential to be affected by the alleged deficient practice of improper handwashing and glove use/isolation precautions related to infection control/prevention. **B)** All licensed staff (FT/PT/PRN) will be re-inserviced re: the policy for glucometer cleaning (CL-NUR-1026) when used with multiple residents, with specific focus on designated solution to prevent transmission of blood borne diseases. Specific solution/disinfectant for glucometer cleaning will be added to the new employee Orientation Competency Checklist under “Glucose Monitoring” to ensure all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	she indicated she always cleaned the glucometer with an alcohol pad. During an interview with the DON on 12/19/12 at 10:00 a.m., she indicated only 1 glucometer is used for all residents needing accuchecks on the split unit. She indicated at this time LPN #2 was the nurse taking care of all of the 3 residents on the split hall who needed accuchecks. A facility policy, dated 2/3/10, titled "Blood Glucose Monitoring," received from the DON on 12/12/12 at 5:35 p.m., indicated "...If a meter that has been used for one resident must be reused for another resident, the device must be cleaned and disinfected with a bleach preparation...(DO NOT use alcohol or ammonia solution)... During an interview with the DON on 12/12/12 at 4:28 p.m. she indicated it is the facility policy to clean glucometers with "saniwipes." The DON indicated the saniwipes are saturated with a bleach solution) 2. During an observation of a medication administration on the "back unit," on 12/12/12 at 4:40 p.m., RN #1 entered the room of Resident		new employees are educated to the policy/standard of practice for compliance. All licensed staff (FT/PT/PRN) will be re-inserviced on the Transmissions Precautions: Contact policy (CL-IC-3027) with specific focus on handwashing. **C)** Random observations of licensed staff performing routine glucose monitoring/cleaning will be done by DON/ADON/designee daily M-F on all shifts to ensure compliance with disinfecting glucometer. Any identified concerns will be corrected immediately. Random observations of licensed staff providing care for isolation residents will be done by DON/ADON/designee daily M-F on all shifts to ensure compliance with proper handwashing practices. Any identified concerns will be corrected immediately. **D)** Results of random observations of glucometer cleaning and handwashing observations will be monitored at bi-monthly CQI meetings and quarterly Quality Assurance meetings with IDT. **E)** Date of compliance with proposed actions**: January 18, 2013**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#78. A sign on Resident #78's door indicated visitors should check with the nurse prior to entering the room. RN #1 washed her hands in Resident #78's bathroom. RN #1 then came out of the bathroom, closed the bathroom door with her bare hands, walked up to the medication cart, prepared Resident #78's medication by opening the medication cart drawers and removing the medications. RN #1 then reentered Resident #78's room and gave the resident the medications. RN#1 was not wearing gloves. RN#1 then opened Resident #78's bathroom door with her bare hands, threw away the pill container, closed the bathroom door with her bare hands, returned to the medication cart and applied hand sanitizer. A review of Resident #78's record on 12/12/12 at 5:00 p.m. indicated the resident was in isolation for Clostridium Difficile. (a bacterium causing diarrhea) A facility policy, dated 10/1/09, titled "Transmission Precautions: Contact," received from the Director of Nursing (DON) on 12/10/12 at 2:45 p.m., indicated "Purpose In addition to Standard Precautions, Contact Precautions are used for residents			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	known or suspected to be infected or colonized with epidemiological important microorganisms that can be transmitted by direct contact with the resident, or indirect contact (touching) with environmental surfaces...Procedure...Wear clean, non-sterile gloves when entering the room...remove gloves before leaving the room and wash hands immediately with an antimicrobial agent After removing gloves and hand washing, ensure that hands do not touch potentially contaminated environmental surfaces...Do this to avoid transfer of microorganisms to other residents or environments..." During an interview with the DON on 12/18/12 at 1:00 p.m., she indicated the staff had inservices on infection control procedures, but "sometimes I think they just forget about the hard surfaces." During an interview with the DON on 12/19/12 at 10:00 a.m. she indicated there were 22 residents residing on the back unit during the evening shift on 12/12/12. She indicated RN #1 was the nurse taking care of these 22 residents. 3.1-18(j)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview, the facility failed to ensure chemicals and sharps were stored securely to prevent access by the residents who were confused and mobile. This deficient practice affected 23 of 25 residents on the secured dementia unit. (Residents #180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 191, 192, 193, 194, 195, 197, 198, 199, 200, 201, 202, 203, 204) Findings Include: 1. On 12/19/12 at 9:00 A.M. the Director of the memory care unit indicated the following 23 of 25	R0148	**Responses to the findings does not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.** In response to the cited alleged deficiency R148; Sanitation and Safety Standards, is the following: **A)** 23 of 25 residents as well as any future residents who	01/18/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents residing on the unit were mobile: Residents #180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 191, 192, 193, 194, 195, 197, 198, 199, 200, 201, 202, 203, 204) On 12/18/12 at 3:00 P.M. the Director of the memory care unit and the Administrator of the facility indicated 25 of 25 residents residing on the memory care unit had a diagnosis of dementia and/or Alzheimer 's. The Director and the Administrator also indicated the activity room was always open and residents were free to come in and out of the activity room and they were not always supervised. 2. On 12/17/12 at 11:55 A.M. Resident 181 was observed in the activity room without supervision from 1:55 A.M. to 12:10 P.M. The activity closet, with double doors standing ajar, had the following items easily accessible: A: 1 27 oz can of Febreeze Pet Odor Eliminator The warning label on the can read "do not spray directly at face. If eye contact occurs rinse well with water, seek medical attention, or call poison control center right away."		will reside on the unit will no longer have access to the activity room closet and the closet will remain locked at all times when not supervised as to not allow access to any hazardous chemicals/toxins. **B)** The Bridge to Rediscovery Director and Activity Director will ensure the closet will remain locked at all times when not supervised by a staff member and all staff will be in-serviced of this alleged deficient practice related to hazardous materials. **C)** The Bridge to Rediscovery Director, Activity Director and Administrator will only have keys for the closet. The Nursing staff will no longer have access to the closet. D) The Bridge to Rediscovery Director, Nursing staff and Activity Director will monitor the double locks to ensure they remain secured. At approximately 5pm Monday through Friday the Activity Director will complete a final check	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	B: 2 9.7 oz. Bottles of Febreeze Air Effects The warning label read "do not spray directly at face. If eye contact occurs rinse well with water, seek medical attention, or call poison control center right away." C: Rustoleum Metallic Paint and Primer 11.0 oz. Warning Label read "may affect brain or nervous system, causing dizziness, headache, and nausea if they are to occur seek medical attention or contact the poison control center immediately. Extremely Flammable." D: Krylon Low Odor Clear Finish 11.0 oz. Warning label read "In case of eye contact flush thoroughly with large amounts of water for fifteen minutes, seek medical attention, or contact poison control center right away." On 12/18/12, the activity room as a whole was observed unsupervised from 12:20 to 1:10 and the doors were open. On 12/18/12 at 12:20 the activity room closet doors were observed ajar with the following items easily accessible: A: 3 screwdrivers		for the day. The Closet will remain locked throughout the night and on weekends. **E) Date of compliance with proposed actions is January 18, 2013**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	B: 1 staple remover C: 2 hot glue guns D: 1 1.7 oz. bottle of [brandname] antibacterial hand gel with a warning label that read "if swallowed seek medical attention or contact poison control center right away." E: 2 8.0 ounce bottles of hand sanitizer. 1 bottle was full and the other was 3/4 of the way full. Warning Label read " If swallowed seek medical attention or contact poison control center immediately." F: One 11.0 oz. can of Design Master Spray Paint. Label read "DANGER: harmful if inhaled or absorbed through the skin". On the back of the can there were Health Hazards" Causes irritation may cause allergic skin reaction. Over exposure causes nausea, headache, vomiting, unconsciousness, or death may occur if too much is breathed. May cause heart irregularities. First Aid always get prompt medical attention for any ill effect. If in eyes, immediately flush eyes with water, if on skin wash with soap and water, if inhaled get fresh air and medical attention." G. One 6.0 oz can of [name brand]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Sport Sunscreen Spray (water resistant for 80 minutes) Warning Label read "if swallowed seek medical attention or contact poison control center right away." H: One 6 oz. Bottle of [name brand] spray sunscreen very water resistant. Warning label read" if swallowed seek medical attention immediately or contact poison control center immediately." I: One 45 pack of Antibacterial Wet Wipes Warning Label read "if swallowed seek medical attention immediately or contact poison control center immediately." J: 3 pairs of scissors On 12/18/12 at 1:10 P. M the activity director was interviewed in reference to the hazards found in the activity closet which were easily accessible to the residents. She indicated that she did usually lock the closet doors because the staff needed access to the contents of the closet throughout the day. She also indicated the doors were equipped with locks on both the top and the bottom of each door and she did lock the closet doors before she left at night. She indicated she is understood that considering			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the diagnosis of these residents in particular, the closet doors should be locked at all times and/or the residents should be under supervision while having the ability to access those items. In an interview on 12/18/12 at 3:00 P.M. with the Director of the memory care unit and the Administrator, they indicated the unit is set up to allow residents the freedom to come and go as the please within the unit boundaries. They also indicated that there are times that the residents are in the activity room without supervision and that the doors should be locked on the closets containing the hazards.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure resident service plans in a secured dementia unit were signed by the resident, or a significant other, for 5 of 5 records reviewed for service plans in a sample of 7. (Residents #181, #190, #195, #200 and #202)	R0217	**Responses to the findings does not constitute an admission or agreement by the facility of the truth of the alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter**	01/18/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. The record of Resident #181 was reviewed on 12/18/12 at 2:10 p.m. Diagnoses for Resident #181 included, but were not limited to, Alzheimer's dementia, anxiety and agitation. Resident #181 was admitted to the facility on 3/1/12. An Individualized Resident Service Plan, dated November, 2012, had been created for Resident #181. The service plan was not signed by the resident or a significant other. 2. The record of Resident #190 was reviewed on 12/18/12 at 11:30 a.m. Diagnoses for Resident #190 included, but were not limited to, dementia and depression. Resident #190 was admitted to the facility on 7/5/10. An Individualized Resident Service Plan, dated November, 2012, had been created for Resident #190. The service plan was not signed by the resident or a significant other.		**of compliance with federal and/or state law.** In response to the cited alleged deficiency R217; Evaluation, is the following: **A)** 5 of the 5 resident service plans will be reviewed and signed by the resident or significant other. **B)** The Bridge to Rediscovery Director will ensure that all current residents have a signed service plan via audits of all charts and future residents will have a signed service plan upon admission evaluation and subsequently every 6 months following. **C)** The Bridge to Rediscovery Director will conduct quarterly audits to ensure that the proper documentation and correct forms are complete and signed. D) The Bridge to Rediscovery Director will conduct quarterly documented audits and facility policy will be followed. **E) Date of compliance with proposed actions is January 18, 2012**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. The record of Resident #195 was reviewed on 12/18/12 at 1:30 p.m. Diagnoses for Resident #195 included, but were not limited to, Alzheimer's dementia and failure to thrive. Resident #195 was admitted to the facility on 9/15/10. An Individualized Resident Service Plan, dated November, 2012, had been created for Resident #195. The service plan was not signed by the resident or a significant other. 4. The record of Resident #200 was reviewed on 12/17/12 at 1:25 p.m. Diagnoses for Resident #200 included, but were not limited to, dementia, depression and Parkinson's disease. Resident #200 was admitted to the facility on 8/22/11. An Individualized Resident Service Plan, dated November, 2012, had been created for Resident #200. The service plan was not signed by the resident or a significant other.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5. The record of Resident #202 was reviewed on 12/17/12 at 11:00 a.m. Diagnoses for Resident #202 included, but were not limited to, dementia and psychosis with paranoia. Resident #202 was admitted to the facility on 9/8/04. An Individualized Resident Service Plan, dated November, 2012, had been created for Resident #202. The service plan was not signed by the resident or a significant other. During an interview with the Director of the secured dementia unit on 12/18/12 at 2:30 p.m. she indicated "We never have the family or resident sign the service plans." She indicated the unit staff meet frequently with family and "family is aware of what is on the service plans." During an interview with the Director of the secured dementia unit on 12/19/12 at 9:00 a.m. she indicated she was not able to find any services plans for Residents #181, #190, #195, 200 and #202 which had been signed by the resident or a significant other.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155294	A. BUILDING 00 B. WING	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORUM AT THE CROSSING	8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A facility policy, titled "Resident Service Plans, dated 11/15/05, received from the Administrator on 12/18/12 at 12:55 p.m., indicated "...Procedure...2. The resident (and family/caregiver if desired by the resident) shall be involved in all aspects of the assessment and service planning process. A meeting shall be held with the resident (family/caregiver) to review and sign the service plan..."			